Provider Insider

Alabama Medicaid Bulletin — **March 2004**

The checkwrite schedule is as follows:

03/05/04 03/19/04 04/09/04 04/23/04 05/07/04

As always, the release of direct deposits and checks depends on the availability of funds.

Medicaid Announces Termination of Patient 1st Program

Effective February 29, 2004, the Patient 1st Program will be terminated. Patients will no longer be assigned to PMPs effective March 1, 2004. Claims with dates of services prior to March 1, 2004, will still require the necessary Patient 1st referral information. Patients were notified through Recipient Notice 04-01. Primary Medical Providers were notified through Provider Notice 04-02.

Case management fees for February will be paid and PMPs will receive their patient lists. Assignments however will not be made for March 2004 nor will changes be accepted for patients wishing to change their PMP.

The termination of the Patient 1st Program does not affect recipient benefit limits. Patients should be told at each visit whether their Medicaid will be accepted for that visit. If a service is noncovered, the recipient should be notified prior to the service being rendered that he/she will be responsible for the payment.

At *www.medicaid.state.al.us*, Medicaid has posted "Frequently Asked Questions" on its website to help PMPs, other providers, and recipients transition out of the Patient 1st Program. This change is necessary due to Medicaid's fiscal constraints.

Referrals

- Effective March 1, 2004, Patient 1st Referrals will no longer be nessessary.
- **Referrals** for **EPSDT** services **should continue** as in the past. The referral should be in writing using the designated referral form while indicating the type of referral as EPSDT.
- The **Referrals** remain the **same** for Restricted **(Lock-In) Recipients**.
- There is only one Agency Referral form 362 (*www.medicaid.state.al.us*). This form accommodates all types of referrals: Patient 1st , EPSDT, and Restricted (Lock-In) Recipients. Please be sure to complete the appropriate blocks on the referrals form. This form will be revised due to the termination of Patient 1st .

If you have any questions, please contact the Medicaid Customer Service Unit at (800) 362-1504.

In This Issue…

Pass It On!

Everyone needs to know the latest about Medicaid.

Be sure to route this to:

- ❒ *Office Manager*
- ❒ *Billing Dept.*
- ❒ *Medical/Clinical Professionals*
- ❒ *Other _____*

Dentists Need PA for Dental Procedures

Dental procedures done in the hospital setting on children 6 years and greater require prior authorization. Please make sure that all codes are listed on the Prior Authorization form 343 when sending in for approval. If you are unsure of all the procedures that will be performed, contact the Dental Program at 334-242-5997 for further instructions.

New Hospital Billing Code for Dental Procedures

Effective January 1, 2004, hospitals began utilizing D9420 when billing for facility fee for dental procedures. This code replaced both Z5158 and Z5363. When billing for D9420, hospitals are now required to obtain the prior authorization number from the dental providers for recipients 6 years old and greater. The prior authorization number assigned to the dental provider will be the same that is used by the hospital for billing. If you need additional information, you can contact the Dental Program at 334-242-5997.

New Provider Electronic Solutions Version 2.02 is Now Available

Provider Electronic Solutions software, version 2.02 upgrade and full install, is now available. To download the software, please go to the Alabama Medicaid website at: *https://almedicalprogram.alabama-medicaid.com/secure/logon.do*, click on WEB HELP, scroll down to the software download section, and download the software. If you currently have version 2.0 installed, you must install upgrade 2.01 before attempting to install upgrade 2.02. For further assistance, or to request the software on CD, contact the EMC helpdesk at 1-800-456-1242.

Attention Psychotherapy Billers

Effective April 1, 2004 - Psychotherapy codes 90808, 90809, 90814, 90815, 90821, 90822, 90828, and 90829 (75-80 minutes) are covered for QMB recipients only. Psychotherapy codes 90804-90829 billed on the same date of service as an E&M service by the same physician or mental health professional group will be denied.

Crosswalk for Submitting 278 PA Request

When submitting 278 Prior Authorization requests, please remember to choose the best value that would indicate the type of service to be performed under Service Tab 1 in the Service Type field. The following crosswalk table provides the various service types to choose from and the category of PA Type it is mapped to:

PA Type	Service Type(s)
01: Durable Medical Equipment	12: DME Purchase 18: DME Rental
02: Eyeglasses	AL: Vision (Optometry)
03: Home Health	42: Home Health Care 44: Home Health Visits
04: Transportation	56: Medically Related Transportation 57: Air Transportation
05: Occupational Therapy	AD: Occupational Therapy
06: Physical Therapy	AE: Physical Medicine
07: Speech Therapy	AF: Speech Therapy
08: Private Duty Nursing	74: Private Duty Nursing
09: Ultrasound	4: Diagnostic X-Ray 69: Maternity
10: Targeted Case Management	A4: Psychiatric A9: Rehabilitation
12: Medical	1: Medical Care
13: Psychiatric Hospital	A7: Psychiatric – Inpatient A8: Psychiatric – Outpatient
15: Surgery (not Dental "D" codes)	2: Surgical (not Dental "D" codes) 70: Transplants
16: Oxygen	72: Inhalation Therapy
17: Prosthetic Devices	75: Prosthetic Devices
18: Inpatient Stay	48: Hospital – Inpatient
19: Other	AC: Rehabilitation – Outpatient
20: Living at Home Waiver	54: Long Term Care
50: Dental	35: Dental Care

Please refer to Chapter 15 of the PES User Manual, Submitting 278 Prior Authorization Requests.

ATTENTION: HOSPITALS AND ASCS

The inclusion or exclusion of a procedure code on the ASC Procedures List (Appendix I in the Provider Manual) does not imply Medicaid coverage. Providers should continue using the AVRS line at EDS (1-800-727-7848) to verify coverage and reimbursement amount for a specific date of service. ASCs may bill surgical procedures within the range of 10000- 69XXX as well as the dental code, D9420. Hospitals may bill these codes as well as other codes listed on the Outpatient Fee Schedule located on the Medicaid website: www.medicaid.state.al.us.

Medicaid Announces Changes to Prior Authorization Form 342

All prior authorization requests for services requiring such must be submitted on the revised Form 342, Alabama Prior Review and Authorization Request, Revised 11/26/03 or for dental procedure codes (D Codes), Form 343, Alabama Prior Review and Authorization Dental Request Form if submitting by paper and not electronically.

(Required If Medicaid Provider) PMP ( )
Requesting Provider
License # or Provider # _____
Phone ( ) _____
Name _____

Recipient Medicaid Number _____
Name _____
Address _____
City/State/Zip _____

Rendering Provider Medicaid # _____
Phone ( ) _____
Fax ( ) _____
Name _____
Address _____
City/State/Zip _____

Date of EPSDT Screening CCYYMMDD _____ DOB _____
Date of Prescription CCYYMMDD _____
First Diagnosis _____ . ____ Ambulance Transport Code ____
Second Diagnosis _____ . ____ Ambulance Transport Reason Codes ____
PA Type _____ Patient Condition _____

(01) Durable Medical Equipment (06) Physical Therapy (12) Medical (18) Inpatient Stay *
(02) Eyeglasses (07) Speech Therapy (13) Psychiatric* (19) Other
(03) Home Health (08) Private Duty Nursing (15) Surgical (20) Living at Home Waiver
(04) Transportation (09) Ultrasound (16) Oxygen
(05) Occupational Therapy (10) Targeted Case Mgt. (17) Prosthetic Devices

DATES OF SERVICE							
Line Item	START CCYYMMDD	STOP CCYYMMDD	PLACE OF SERVICE	PROCEDURE CODE*	MODIFIER 1	UNITS	PRICE/ DOLLARS

Clinical Statement: (Include Prognosis and Rehabilitation Potential) A current plan of treatment and progress notes, as to the necessity, effectiveness and goals of therapy services (PT, OT, RT, SP, Audiology, Psychotherapy, Oxygen Certifications, Home Health and Transportation) must be attached.

_____
_____
_____
_____
_____
_____

*** If this PA is for Psychiatric or Inpatient stay, Procedure Code is not required.**

Certification Statement: This is to certify that the requested service, equipment, or supply is medically indicated and is reasonable and necessary for the treatment of this patient and that a physician signed order is on file (if applicable). This form and any statement on my letterhead attached hereto has been completed by me, or by my employee reviewed by me. The foregoing information is true, accurate, and complete, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Signature of Requesting Provider _____ Date _____

FORWARD TO: EDS, P.O. Box 244036 Montgomery, Alabama 36124-4036

Form 342
Revised 11/26/03

Alabama Medicaid Agency

CHANGES

1. The Removal of the Certification, Recertification / Continued Stay field
2. Date of Birth field added
3. The deletion of PA Types 11 – Drugs and 14 – Wheelchairs
   All requests for wheelchairs must indicate a PA Type of 01 – Durable Medical Equipment.

All PA requests must be submitted to EDS, P.O. Box 244036, Montgomery, Alabama 36124-4036. No requests should be submitted directly to the Medicaid Agency. To obtain a current copy of Form 342, visit Medicaid's website at www.medicaid.state.al.us.

Revenue Codes Have Been Updated

Valid revenue codes for Medicaid billing are 170-174 and 179. Revenue code 175 was deleted on January 1, 2004.

Revenue codes 170 (Nursery) and 171 (Nursery/Newborn) are billed for well-baby care and are included on the mother's inpatient claim. Well-baby care is not separately billable.

Revenue codes 172 (Nursery / Continuing Care), 173 (Nursery/Intermediate Care), 174 (Nursery/Intensive Care), and 179 (Nursery/Other) should be billed only if the newborn's condition meets the established criteria. These services should be billed separately from the mother's claim under the infant's name and Medicaid number. The infant's claim must indicate the valid ICD-9-CM diagnosis codes identifying the conditions that required the higher level of care.

REMINDER

PRIOR AUTHORIZATIONS

Prior authorization requests submitted with January 2004 dates of service and beyond must have the new HIPAA compliant procedure codes indicated on Form 342. Please refer to your chapter of the Medicaid Billing Manual to determine what procedure code should be used.

Inappropriate Billing Continues for Eye Care Providers

Inappropriate billing continues to occur for frames and/or lenses. Only providers who furnish the eyeglasses i.e., frames/lenses, should bill for these services. As a result, the Agency has established a new mechanism for resolution of inappropriately billed eyeglasses effective April 1, 2004. Classic Optical Laboratories, Inc. has agreed to perform the procedures outlined below.

1. Classic will contact the ordering provider directly to determine if they inappropriately billed Medicaid;
2. The provider will then make an adjustment to the claim on-line;
3. Classic will subsequently re-file their claim for payment.

Medicaid is confident this solution should resolve 70 percent or more of denied claims.

Clarification of Replacement Codes for Z4998

The January 2004 Provider Manual contains several incorrect replacement codes for Z4998 (administration fee). Crosswalks in Appendix C, Family Planning, Appendix H, Physician Drug List, Appendix I, ASC Procedures List and Appendix O, CRNP and PA Services, list 90471, 90782, 90783, 90784 and 90788 as replacements for Z4998. Only 90471 and 90782 are to be used as crosswalks for Z4998. The other codes are covered by Medicaid, but are not to be used in the same situations where Z4998 would have been submitted prior to January 1, 2004. Medicaid apologizes for any confusion this may have caused.

Discontinue Billing Place of Service 99

Effective immediately, providers other than Children's Specialty Service, Pharmacy, Rehab, Waivered Services, Preventive Health Education and Targeted Case Management should discontinue billing place of service 99 - unlisted facility. Providers should designate the actual place of service so that claims can be tracked, especially for billing to other insurance carriers. POS 99 is normally not recognized by other payers and results in denials of claims submitted by Medicaid to those payers for reimbursement.

Prior Authorization Information for Pharmacy Providers

Effective February 19, 2004, the Alabama Medicaid Agency implemented a Prospective DUR Therapeutic Duplication "hard" edit for pharmacy claims. A "hard" edit requires an override approval from Medicaid before the claim will adjudicate.

Therapeutic Duplication is the prescribing of two or more drugs from the same therapeutic class such that the combined daily dose increases the risk of toxicity or incurs additional program costs without additional therapeutic benefit. This edit will warn pharmacists when a claim is submitted for a systemically absorbed drug in the same therapeutic class or a non-systemically absorbed drug with the same route of administration as another drug in the patient's active medication history. The therapeutic duplication edit takes into consideration the exhaustion of previously dispensed medications by calculating the days supply and the dispensed date.

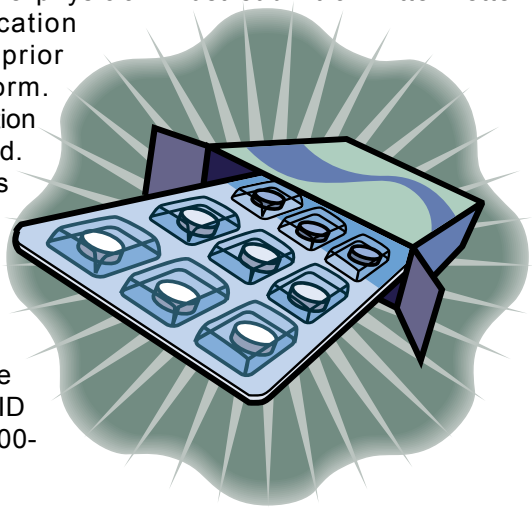
The Therapeutic Duplication Edit will be implemented for the following classes of drugs.

Anti-hypertensives
Anti-psychotics
Triptans

Effective March 1, 2004, the Alabama Medicaid Agency will require prior authorization for the payment of non-preferred brand Anxiolytics, Sedatives, Hypnotics, Anti-hyperlipidemics and ADHD agents. The new prior authorization request form is available on the Medicaid website and should be utilized by the prescribing physician or the dispensing pharmacy in requesting prior authorization. Requests may be called in, faxed or mailed to:

Health Information Designs (HID)
Medicaid Pharmacy Administrative Services
P. O. Box 3210
Auburn, AL 36832-3210
Fax: 1-800-748-0116
Phone: 1-800-748-0130

PA requests failing to meet Medicaid criteria will be denied. If the prescribing physician believes medical justification should be considered, the physician must submit a written letter of medical justification along with the prior authorization form. Additional information may be requested. Staff physicians will review this information.



Questions regarding prior authorization procedures should be directed to the HID help desk at 1-800-748-0130.

EDS Provider Representatives

G R O U P 1

North: Jenny Homler and Marilyn Ellis

Bibb, Blount, Calhoun, Cherokee, Chilton, Clay, Cleburne, Colbert, Coosa, Cullman, DeKalb, Etowah, Fayette, Franklin, Greene, Hale, Jackson, Jefferson, Lamar, Lawrence, Lauderdale, Limestone, Madison, Marion, Marshall, Morgan, Pickens, Randolph, Shelby, St. Clair, Talladega, Tuscaloosa, Walker, Winston

jenny.homler
@eds.com
334-215-4142

marilyn.ellis
@eds.com
334-215-4159

South: Melanie Waybright and Denise Shepherd

Autauga, Baldwin, Barbour, Bullock, Butler, Chambers, Choctaw, Clarke, Coffee, Conecuh, Covington, Crenshaw, Dale, Dallas, Elmore, Escambia, Geneva, Henry, Houston, Lee, Lowndes, Macon, Marengo, Mobile, Monroe, Montgomery, Perry, Pike, Russell, Sumter, Tallapoosa, Washington, Wilcox

Nurse Practitioners
Podiatrists
Chiropractors
Independent Labs
Free Standing Radiology

melanie.waybright
@alxix.slg.eds.com
334-215-4155

denise.shepherd
@alxix.slg.eds.com
334-215-4132

CRNA
EPSDT (Physicians)
Dental
Physicians
Optometric
(Optometrists and Opticians)

G R O U P 2

Rehabilitation Services
Home Bound Waiver
Therapy Services
(OT, PT, ST)
Children's Specialty Clinics
Prenatal Clinics
Maternity Care
Hearing Services
Mental Health/Mental Retardation
MR/DD Waiver
Ambulance
FQHC

stephanie.westhoff
@alxix.slg.eds.com
334-215-4113

tracy.ingram
@alxix.slg.eds.com
334-215-4158

Public Health
Elderly and Disabled Waiver
Home and Community
Based Services
EPSDT
Family Planning
Prenatal
Preventive Education
Rural Health Clinic
Commission on Aging
DME
Nurse Midwives

G R O U P 3

Ambulatory Surgical Centers
ESWL
Home Health
Hospice
Hospital
Nursing Home

ann.miller
@alxix.slg.eds.com
334-215-4156

shermeria.hardy
@alxix.slg.eds.com
334-215-4160

linda.hanks
@alxix.slg.eds.com
334-215-4130

Personal Care Services
PEC
Private Duty Nursing
Renal Dialysis Facilities
Swing Bed

New Reassigned National HCPC Codes

Effective January 1, 2004, the Alabama Medicaid Agency replaced locally assigned codes and modifiers with National HCPC codes and modifiers. Listed below is a list of the old codes and one modifier that have been crosswalked to new National HCPC codes and modifiers.

OLD CODE	NEW CODE	OLD CODE	NEW CODE
Z5117	E1050	Z5220	E0779
Z5119	A4628	Z5221	A4222
Z5120	A4625	Z5222	A4632
Z5120	A4629	Z5223	E1399 & E1340
Z5121	A7520	Z5311	A4335
Z5122	E0280	Z5313	99503
Z5124	E1037	Z5314	A9900
Z5129	E1091	Z5315	A9999
Z5133	E1091	Z5439	E1220
Z5134	E1091		

CODE	NEW MODIFIER
E1399	EP
B9998	EP

Prior Authorization requests approved with dates of service prior to January 1, 2004 for procedure codes E1399 and B9998, should continue to be billed using the original approved ZN modifiers. For prior authorization requests received and approved for dates of service January 1, 2004 and thereafter, prior authorization requests for procedure codes E1399 and B9998 should be submitted with the EP modifiers.

Effective January 1, 2004, Augmentative Communication Devices will be covered using the following procedure codes:

(E2500), (E2502), (E2504), (E2506), (E2508), (E2510), (E2511), (E2512), (E2599) type of service R and P. Repairs for these codes will be covered using procedure code E1399 and E1340. Repairs for the Pump for Iron Chelation Therapy(E0779) will also be covered using E1399 and E1340 .

Effective February 1, 2004 Respiratory assist devices, bi-level pressure capability (BIPAP) will no longer be covered using procedure code E1399 ZN. They will be covered using the appropriate HCPC code listed below:

(E0470-R), (E0471-R), (E0472-R)

Effective February 1, humidifiers will be covered using the appropriate HCPC code (E0561-R) or (E0562-R).

Effective January 1, 2004, Hospital beds to accommodate weight capacities 350 pounds and above will no longer be covered using procedure code K0549 and K0550. These beds will now be covered using the appropriate HCPC code E0303 or E0304.

Request for coverage of durable medical equipment must be received by EDS within thirty (30) days after the equipment is dispensed. When the request is not received within the 30 day time frame for ongoing rental equipment (such as apnea monitors, pulse oximeters, oxygen, CPAC machines, BIPAP machines, compressors), the 30 days will be calculated from the date the prior authorization request is received by EDS. All prior authorization requests received with a date greater than 30 days from dispensed date will be assigned an effective date based on actual date received by EDS if the recipient continues to meet medical criteria. No payment will be made for the days between the dispensed date and the date assigned by the Prior Authorization Unit.

Medicare / Medicaid Crossover Claims

It was discovered after Medicaid's conversion to the HIPAA Compliant Transaction and Code Set claims processing system on December 13, 2003 that Medicare Fiscal Intermediaries are unable to send crossover claims in the HIPAA compliant format. In contacting various Medicare Intermediaries it may be this summer before they are able to submit HIPAA compliant crossover claims.

Because of this no Medicare claims automatically crossed over on the January 2 checkwrite. In the interim we are working to write programs to convert crossover claims sent in the old format to a claim that can be processed in our HIPAA compliant system. Since each Medicare Intermediary (Cahaba, Palmetto, Trailblazers, etc.) uses a different format we will have to write separate programs for each fiscal intermediary. We have completed the program to convert for Cahaba (Blue Cross/Blue Shield of Alabama) medical and LTC claims. As a result, 130,000 crossover claims were adjudicated in the January 16 checkwrite. Our next priority is Cahaba's inpatient and outpatient claims. We are testing this conversion program at this time.

We are saving the crossover tapes from each Medicare Fiscal Intermediary so that we can process their claims once our conversion programs are written. If you need to have your crossover claims processed before we can complete the conversion programs our Provider Electronic Solutions software does provide for crossover claims submission. We have published specifications vendors can use to submit crossover claims as well. Please note that any claims from crossover tapes processed after you or your vendor submits the same claim will produce a denied claim on your EOP.

We will update our web site (*www.medicaid.state.al.us*) with more information on crossover claims as more conversion programs are written and additional crossover claims are processed.

www.medicaid.state.al.us

Alabama Medicaid

In The Know

General Information Providers Need to Know When Billing to the Alabama Medicaid Agency

Billing Recipients

Providers should be reminded that it is not acceptable to bill patients conditional on Medicaid paying. Nor may providers collect scheduling fees to ensure patient compliance. While the Agency understands the issue of appointment no-shows, this practice is in direct violation of Medicaid regulations. Please note the following guidelines from the Medicaid Provider Manual that apply to **all** providers:

7.1.7 Billing Recipents

When the provider of medical care and services files a claim with the Medicaid Program, the provider must agree to accept assignment. By accepting assignment, the provider agrees to accept Medicaid reimbursement, plus any cost-sharing amount to be paid by the recipent, as payment in full for those services covered under the Medicaid Program. The Medicaid recipient, or others on the recipient's behalf, must not be billed for the amount above that which is paid on allowed services.

Providers identified in violation of the policy will be referred to the proper authorities.

State Fiscal Year 2003-2004 Checkwrite Schedule

03/05/04	05/21/04	08/06/04
03/19/04	06/04/04	08/20/04
04/09/04	06/18/04	09/03/04
04/23/04	07/09/04	09/10/04
05/07/04	07/23/04	

Alabama Medicaid Bulletin

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Montgomery, AL 36124-4032

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